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LOUIS W. SCHULTZ (D.D.S., 1920; B.S., 1922; M.D., 1928, University of Illinois) contributed an article in the September, 1937 issue of this magazine on his TREATMENT BY INJECTION FOR SUBLUXATION OF THE TEMPOROMANDIBULAR JOINT. A more detailed professional biography appeared in that number.

RALPH LEONARD IRELAND, D.D.S. (University of Nebraska, 1929) presented a pictorial description of his technique for IMMEDIATE TEMPORARY BRIDGES FOR ANTERIOR TEETH in the October, 1936 number of this magazine, at which time Doctor Ireland's professional biography was given. To assist the reader in visualizing the technique applied in his present report, a pictorial "flash back" to his previous article accompanies his PRACTICAL APPLICATION OF THE IMMEDIATE TEMPORARY BRIDGE in this issue.

G. A. STEVENSON, JR., B.S., D.D.S. (University of Chicago, 1916; Northwestern University Dental School, 1923) is the author of this month's published letter to the Editor. In October, 1935, Doctor Stevenson described a METHOD OF REPAIRING BROKEN BRIDGE FACINGS.

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Fixed Bridge Esthetics

LEO S. SEIDNER, D.D.S., Chicago

THE PROGRESS MADE IN the last decade in the design and construction of fixed bridge restoration has been definitely marred by the lack of a fixed bridge pontic that would eliminate the unsightly display of gold, particularly in mandibular restorations of lost teeth. Often the best efforts are minimized and enthusiasm is dimmed by a feeling of helplessness in response to patients' demands for a bridge restoration, the artificiality of which would be less obvious. In an effort to meet this demand, dentists frequently resort to unsound and illogical means, such as construction of removable bridge restorations where these are not indicated, or improvisations at a sacrifice to hygiene or to strength and durability.

Requirements

To meet the requirements of a modern fixed bridge pontic, the following qualifications are necessary: (1) functional resistance to normal masticatory stresses; (2) universal applicability; (3) sanitation; (4) nonirritability to soft tissues, and (5) esthetics.

Application and Advantages

The pontic to be described is particularly applicable in fixed bridge restorations in posterior mandibular regions. It is likewise applicable in posterior maxillary restorations where there is no objection to the showing of a slight gingival collar of gold. In maxillary restorations the choice must be made between a slight showing of gold at the gingival, as described in this technique, and the occlusal and incisal gold, as presented by the usual porcelain-faced pontics.

Aside from its esthetic value in modern dental restorations, tending to meet a prevalent demand, it may be stated that because this pontic consists entirely of a solid block of porcelain devoid of pins, post-holes, or other features that tend to weaken a pontic and render it susceptible to fracture under the strain of mastication, it affords almost unlimited use

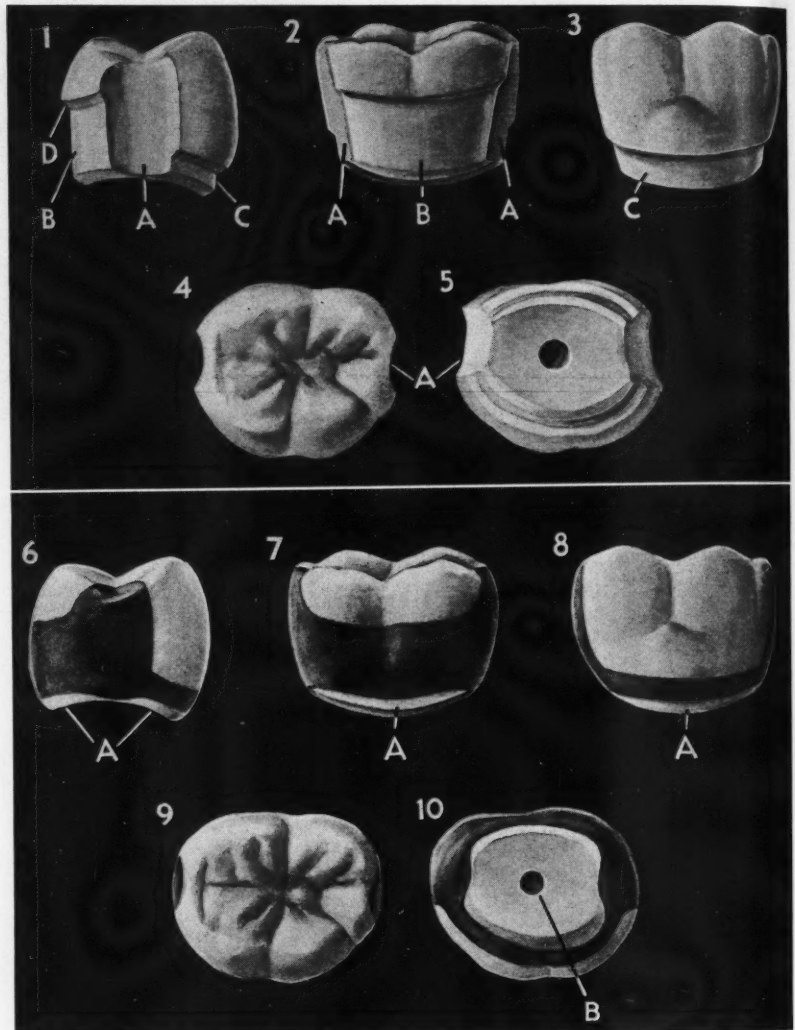


Fig. 1—A, Proximal preparation; B, axial wall of lingual surface; C, gingival preparation; D, lingual mesio-distal (transverse) shoulder.

Fig. 2—Lingual view.

Fig. 3—Buccal view.

Fig. 4—Occlusal view.

Fig. 5—Gingival view with post-hole in position.

Fig. 6—Lateral view of pontic waxed and carved.

Fig. 7—Lingual view of pontic waxed and carved. A, Border of porcelain exposed.

Fig. 8—Buccal view. A, Buccal gingival marginal border of porcelain exposed.

Fig. 9—Occlusal view.

Fig. 10—Gingival view.

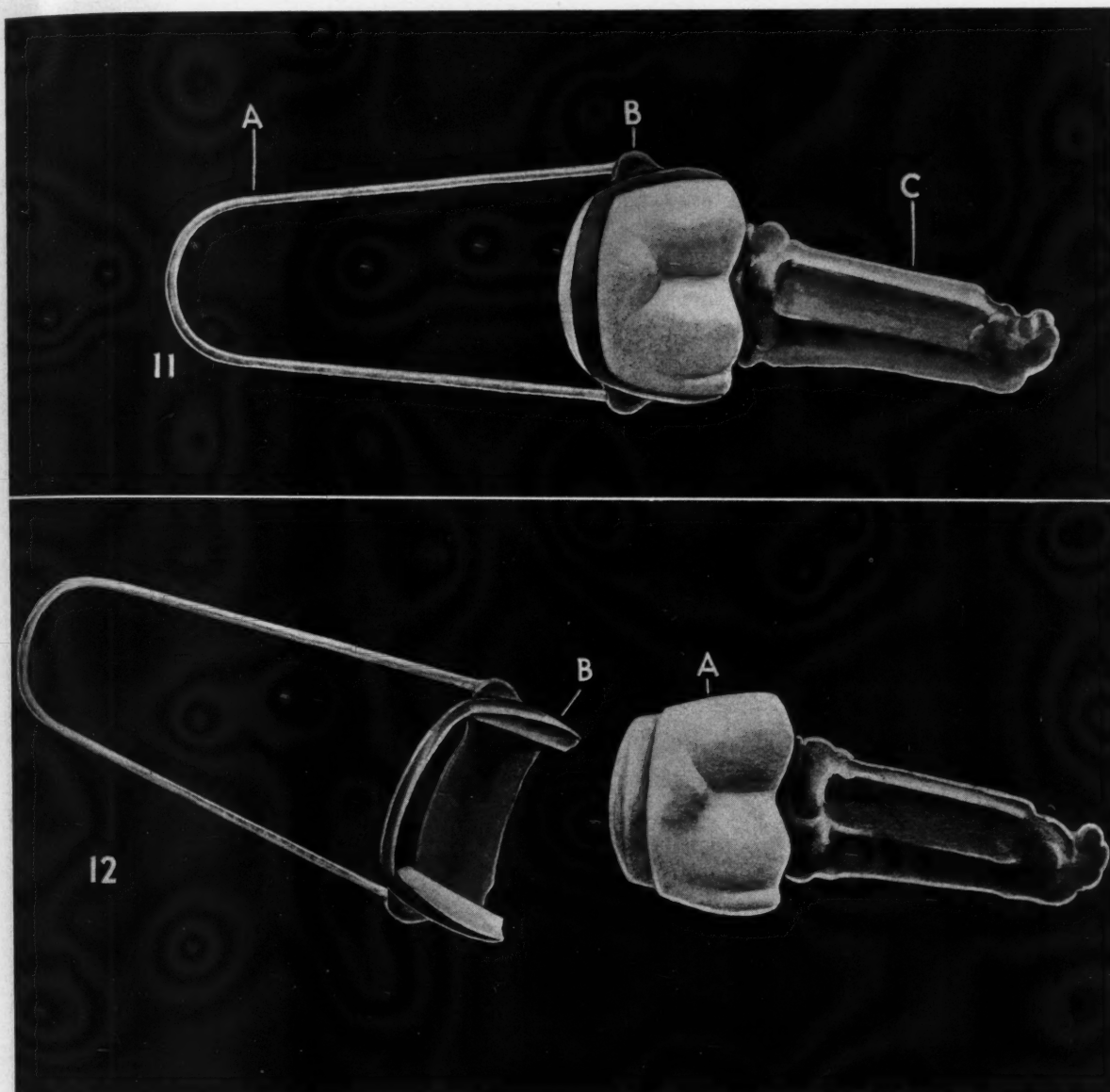


Fig. 11—A, Paper clip sprue; B, sticky wax sealing sprue to wax pattern; C, bar of sticky wax to act as handle for the removal of pontic from wax pattern.

Fig. 12—A, Pontic withdrawn from wax pattern. B, Pattern ready for investment.

with less risk than is ordinarily the case except when an all-cast gold pontic is the only available means of restoring a lost tooth.

Dental practitioners who prefer to perform their own laboratory work will find it comparatively easy to prepare this tooth.

Material

This pontic is prepared from the ordinary tube tooth, several types of which are available. A porcelain tube

in which the post-hole does not penetrate the occlusal surface is selected to fit the case. It is alined in the usual manner on the articulated model, and ground into gingival position as well as into occlusion. At this stage it is well to run up a plaster alinement matrix, and when separated, the following is the technique of preparing the retentive mechanism:

Technique

1. With suitable stones and carbo-

rundum discs a modified vertical box is prepared on the proximal surfaces of the tooth, similar to the preparation of the proximal surface of a natural tooth, for the reception of an inlay, except that the buccal wall does not extend so far buccally as would be the practice in extension for prevention (Fig. 1,A). Care must be taken that the mesial and distal preparations are parallel to each other.

2. The lingual preparation is then accomplished by outlining the extent

of the gold encasement desired, so that the least amount of gold will show when viewed occlusally (Fig. 2).

3. The height of the shoulder is determined by the length of the bite and the amount of encasement desirable to provide the maximum amount of support for the porcelain pontic (Fig. 1,A). By means of a carborundum disc a mesio-distal shoulder is cut sufficiently below the linguo-occlusal marginal ridge to assure invisibility of the backing without loss of strength resistance to this portion of the porcelain pontic. The shoulder extends into the mesial and distal box preparation, the depth to be determined by the thickness of gold enforcement necessary in the case. From 1 mm. to 1.5 mm. will suffice in most instances.

4. The portion below the shoulder of the porcelain tooth is then relieved to the thickness of the shoulder (Fig. 1,B); all undercuts are avoided so as

to facilitate withdrawing the wax pattern (Fig. 3).

5. The preparation for the gingival collar (Fig. 1,C) is accomplished in the same manner in which the lingual shoulder was provided; the same precautions are taken against undercuts as provided in the previous step.

6. Fig. 1 illustrates the tooth from a lateral view and will give an idea of its general appearance. It is now advisable to examine the tooth in all its phases to make sure that no undercuts are present anywhere, in order to assure withdrawal of the wax pattern without distortion. This accomplished, the pattern is waxed up by either of two methods.

1. The tooth is lubricated with either cocoa butter or glycerin, after which by means of a hot spatula, wax is flown to cover the entire preparation and carved to anatomic outline (Figs. 6, 7, and 8).

2. If preferred, an impression is tak-

en by forcing the tooth into a matrix filled with inlay wax and held under compression until the wax has cooled; the matrix is then removed and the pattern carved. That being accomplished, a pellet of cotton between the fingers is used to polish the pattern and burnish the margins into perfect adaptation with the tooth. Withdrawal of the wax pattern from the pontic is accomplished by the use of an ordinary paper clip. This clip, which will later serve as a sprue for casting, is heated and secured to the pattern with sticky wax (Fig. 1,A). A bar of sticky wax held over the flame is then secured to the occlusal surface of the pontic and cooled (Fig. 11,C). With the paper clip held between the fingers of one hand and the bar of sticky wax in the other, gentle torsion is applied, and if no undercuts are present and the tooth has been thoroughly lubricated, it will readily withdraw from the wax pattern.

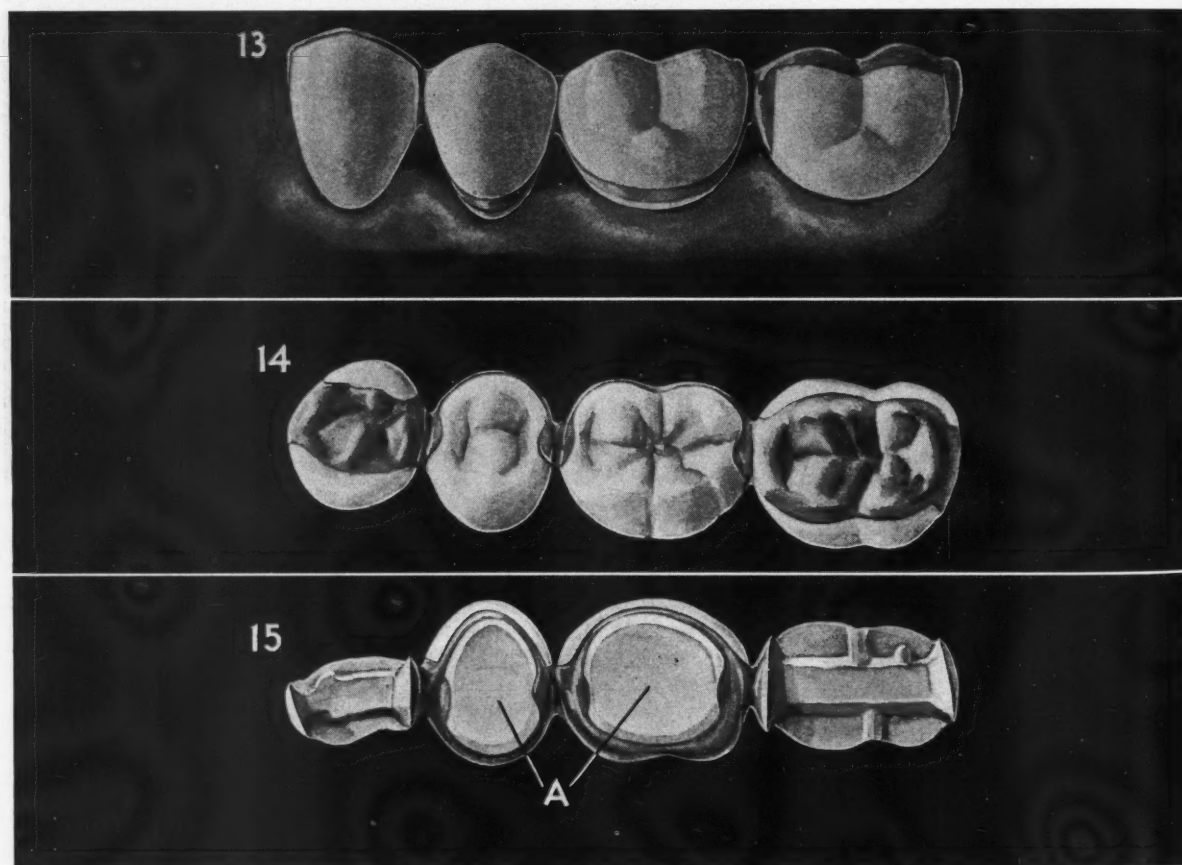


Fig. 13—Buccal view of completed bridge in position.

Fig. 14—Occlusal view.

Fig. 15—Gingival view.

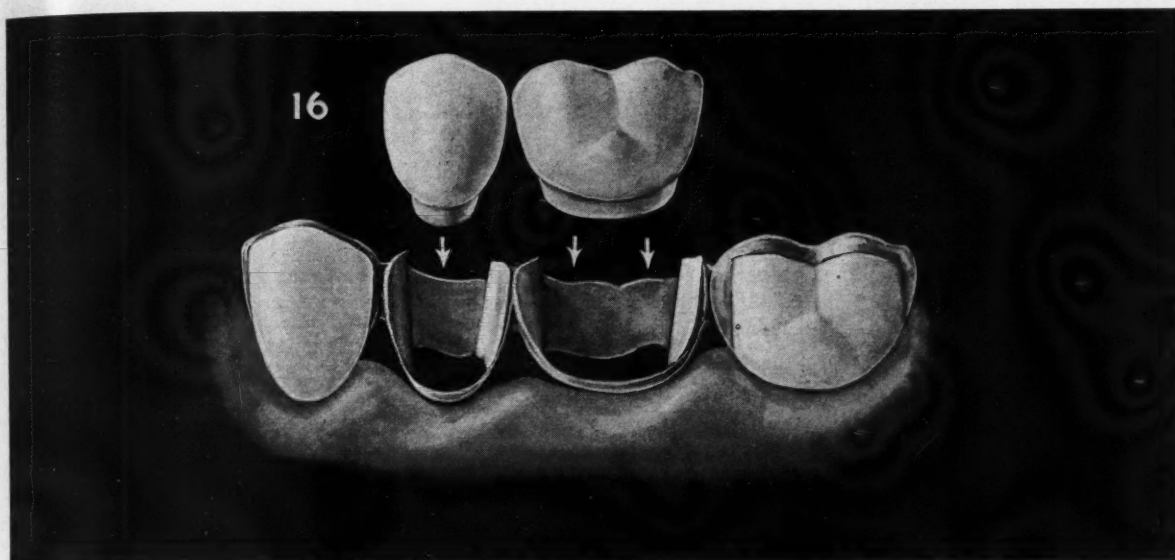


Fig. 16—Relative position of pontics within gold encasement and their manner of displacement.

7. *Investment*—The wax pattern is invested by the same procedure that is employed in the investment of any gold restoration. An investment is used that will expand sufficiently to compensate for the shrinkage in wax and gold, and the casting is made. When the casting is completed, it is fitted to the tooth and examined closely for proper fit and marginal adaptation. The gold encasement is now trimmed, the margins are burnished, the gingival marginal borders of the porcelain exposed and made free from contact of gold with the gum tissues (Fig. 6,A).

7. *Assembling*—The pontics are alined on the model, as indicated by the plaster alinement-matrix, and

waxed into position by means of sticky wax. A matrix is run up of the lingual surfaces of the assembled pontics in their proper relationship with the abutment teeth, and when set, it is separated. The bridge is disassembled; the abutments are removed from the working model; the porcelain pontics are removed from their encasements (gold backings), and each member of the bridge is carefully placed in its position within the lingual alinement matrix and secured to it with sticky wax. The joints are waxed where soldering is to take place and the matrix is lubricated to facilitate separation of the matrix from the soldering investment. The case is invested, care being taken not

to embed the matrix within the investment so that it can readily be separated. When the investment has set, the matrix is removed, and the usual procedure of soldering followed.

The bridge is now tried in the mouth of the patient, the bite checked, and the relationship of the pontics with the gum tissue corrected if necessary. The post-hole of the pontic (Fig. 6) is closed by fusing of porcelain into it, after which the gingival surface of saddle is glazed (Fig. 15).

Before the pontics are cemented into their encasements, it is well to roughen the retentive surfaces to assure maximum adhesion of the cement to the porcelain surfaces.

30 North Michigan Avenue.

Coping and Post in One-Piece Casting

SAMUEL SLAFF, D.D.S., Mount Vernon, New York

THE OBJECT OF THIS paper is to present a technique for the casting of a coping and post in one piece. The method to be described not only builds a stronger preparation but also affords greater protection for the root with no attendant destruction of the surrounding tissues. This procedure may be employed either in the case of an individual restoration, or as an abutment for a bridge.

Examination of the patient shows an abraded and broken down condition, with insufficient tooth structure to allow a restoration satisfactory enough for a necessary bridge abutment. Thus the conditions present indicate the advisability of employing the technique to be given.

Technique

Preliminary Procedure—1. Roentgenograms are taken to determine whether there are any pathologic conditions.

2. With observations normal, employment of the pulp-tester indicates that the tooth is vital.

3. With completion of these preliminary examinations, remove the

pulp and fill the root-canal under the usual aseptic procedure. Allow at least three days to elapse before the next appointment in order to make certain that there are no signs of pericementitis.

Preparation of Root—1. On the patient's next visit proceed to cut down the crown of the tooth to the gum line and enlarge the canal to the correct diameter by use of the drill. The opening into the canal must reach as far below the gingival margin as the completed crown will extend above it.

2. In order to prepare the tooth so that the subsequent beveling of the root will not lacerate the gums, and to create a neat appearance between visits, the following steps must be taken:

(a) Fit a tooth-form to the root, making certain that in festooning, the form is permitted to overhang the margins of the face of the root (Fig. 1).

(b) Bend an ordinary wire paper clip into the shape of a cane, and lay it aside momentarily (Fig. 2).

(c) Fill the canal and tooth-form

with softened baseplate gutta-percha.

(d) Heat the prepared paper clip, and insert the straight portion into the canal.

(e) Press the tooth-form over the bent end and slightly beyond the gingival margin, thus the gum tissue will be forced away. Inasmuch as any surplus material will further the object in view, it is not necessary to remove any that may exist (Fig. 2).

The patient is then discharged, but for no longer than twenty-four hours in order to prevent the possibility of a gingival irritation.

3. On removal of the tooth-form at the patient's next visit, it will be noticed that the gum tissue is forced away from the root about 1 or 2 mm. (Fig. 3). With a Miller's stone, about 1 inch in diameter, on a handpiece, make a complete facial cut on the root, reaching from the canal to the buccal-lingual surface (Fig. 4). With a Miller point, proceed to cut a 45 degree bevel around the face of the root. Such preparations will permit the construction of a casting that will be flush with the root (Fig. 5). This is in contradistinction to the ordinary



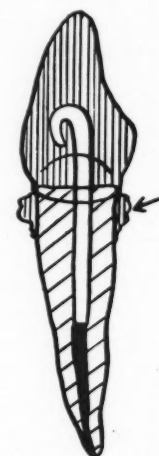
Tooth form

Fig. 1



Wire paper clip

Fig. 2



Surplus

Gum tissue removed
from root

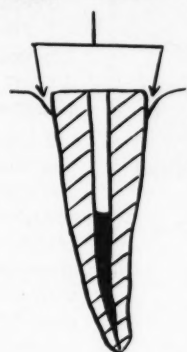


Fig. 3

stone

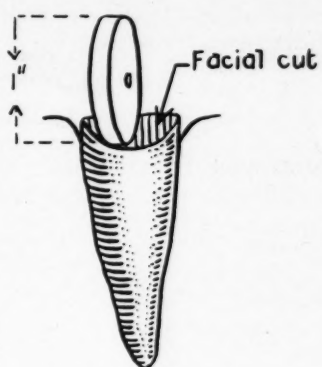


Fig. 4

45° Bevel

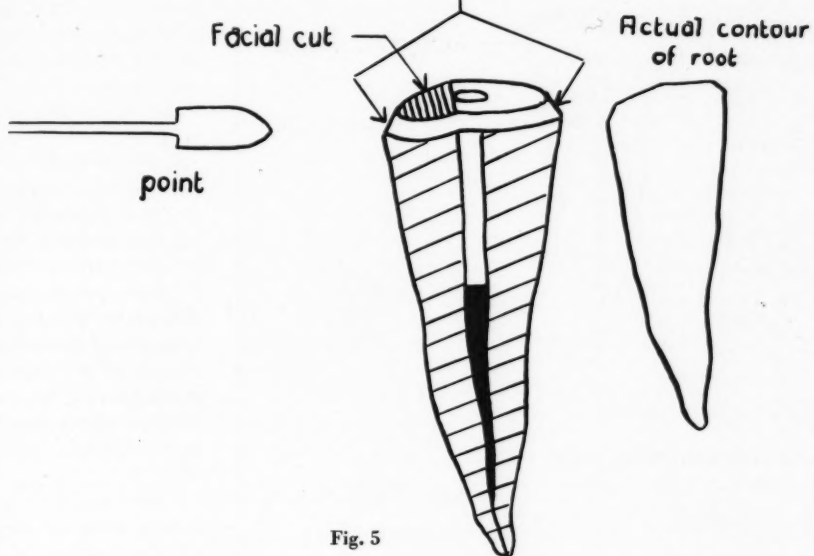


Fig. 5

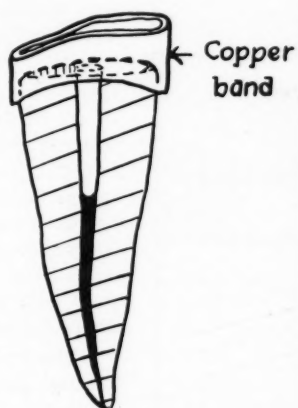
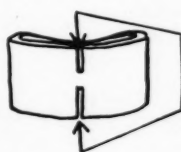
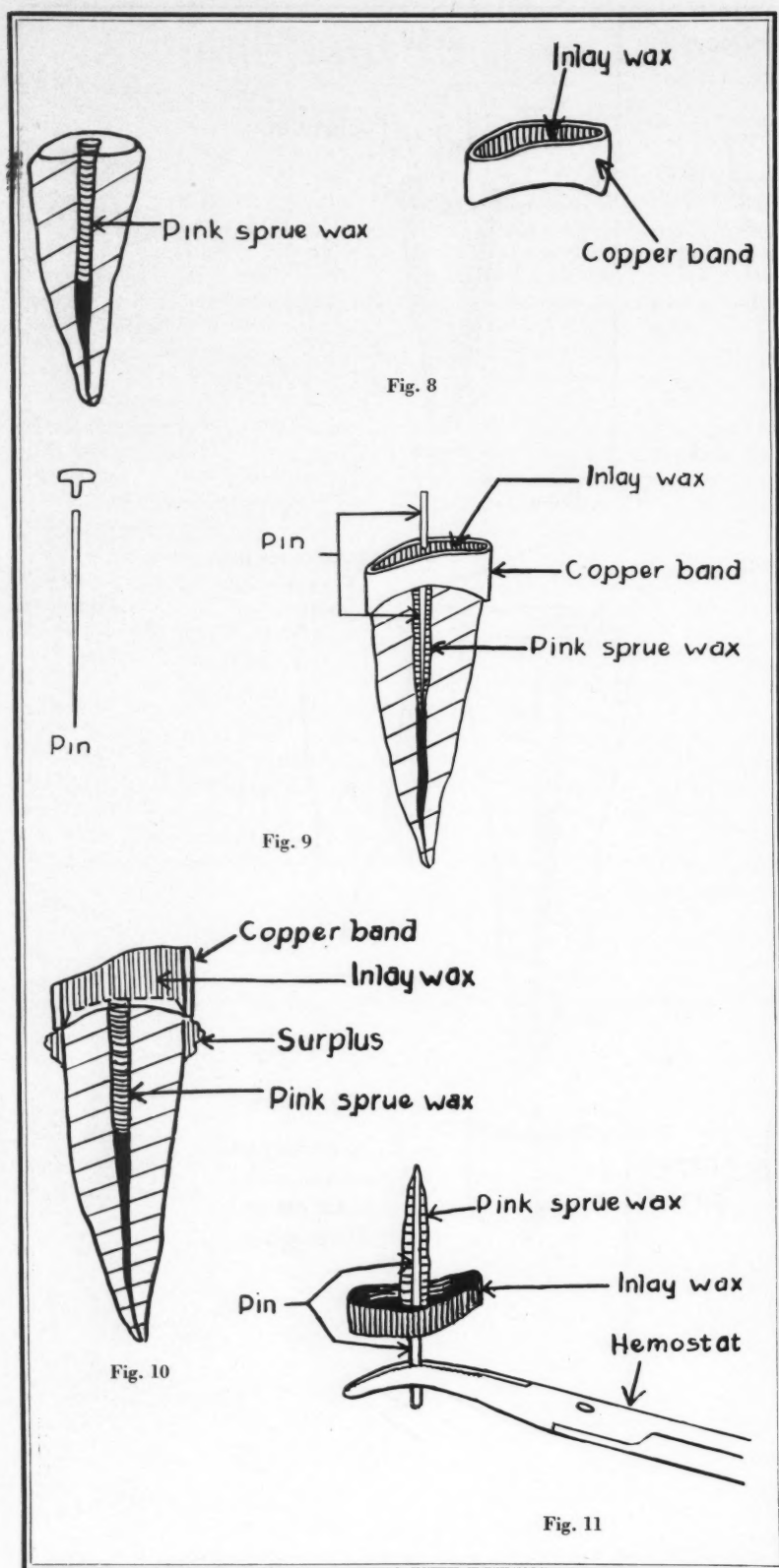


Fig. 6



Cuts on lingual
surface, not
quite clear
through

Fig. 7



band, and the acknowledged cause of tissue laceration and gingival irritation.

Preparation for Wax Impression—

1. Fit a copper band snugly around the root, and festoon it properly. Trim it short so as to resemble a sweated or soldered Richmond band (Fig. 6).

2. On the lingual surface cut part way through from top and almost but not quite to the center. Having then brought the edges of the band together with a pair of straight-nose pliers, lubricate the band on the inner surface and lay aside temporarily (Fig. 7).

3. While the saliva acts as a lubricant in the canal, force some softened pink sprue wax of proper gauge into the canal. Whether or not the wax fits perfectly is immaterial. Burnish the wax flush with the face of the root. Fill the trimmed band with inlay wax and force it over the root. Hold in position as the assistant chills it (Fig. 8).

4. Remove the head of a common pin and heat pin over flame, holding it with a hemostat. While holding the band in position with the index finger and thumb, force the heated pin through the blue wax in the region of the canal, using a quick-in-and-out movement. Allow the pin to rest at the bottom of the canal (Fig. 9). With a warm carving instrument, remove all surplus wax which might lodge between the gum tissue and the band (Fig. 10).

5. Cut through the intact portion of the band on the lingual surface with a number $\frac{1}{2}$ bur on a hand-piece, thereby allowing easy removal and the least amount of distortion to the wax (Fig. 11).

With a hemostat, grasp the pin and remove entire waxing from the tooth. It will be found that the heated pin has expanded the wax within the root to a perfect conformation with the canal walls. Note that this wax has become continuous with that in the band. Observe the twofold purpose of the common pin: It acts as a stabilizer for the wax on removal from the root, and it serves as a sprue.

6. The wax matrix is now ready for casting. Any careful technique may be used.

7. After casting is completed and the cast is thoroughly pickled, cut the

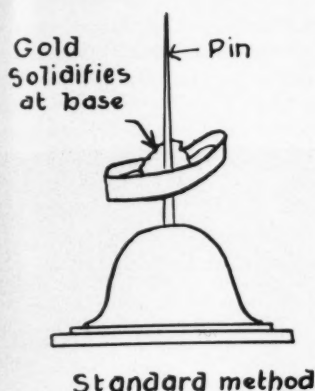


Fig. 12

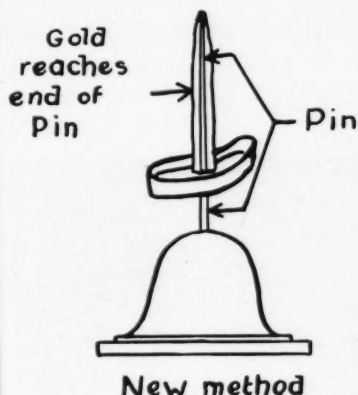


Fig. 13

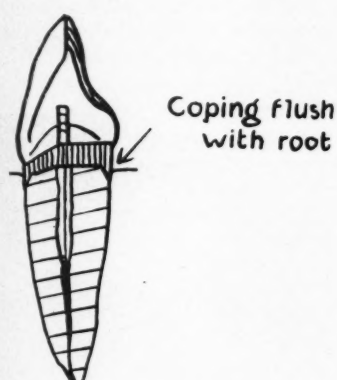


Fig. 14



Fig. 15

nugget away, leaving about 3 mm. of sprue above the coping. This facilitates the proper seating of the casting when taking the impression of the crown.

Advantages

1. *Perfection of Casting*—In the methods commonly employed, after forcing wax into the canal, the operator inserts a hot pin either of gold or of iridioplatinum. On removal of wax the impression appears to be satisfactory; however, because the pin, when invested in the flask and heated is of much lower temperature than the molten gold employed, the gold solidifies on contact with the pin that is within the flask and causes the casting process to stop immediately (Fig. 12). The molten gold, therefore, never reaches the end of the casting of the post. Thus in the other methods only a mechanical union is formed between the pin and the casting, and there is always present the possible separation of the two. In the technique described here, however, a one piece coping and post is developed similar to an inlay (Fig. 13).

2. *Full Protection for Root*—In any method that merely butts the crown against the root, there is insufficient protection against caries. The technique under discussion, however, provides for a coping extending below the gingival margin, thereby completely eliminating such danger.

3. *Prevention of Gingival Irritation*—Whereas it is well recognized that the commonly used band type of preparation generally induces gingival irritation, the technique described resulting in a coping flush with the root obviates all discomfort (Figs. 14 and 15).

11 South Fourth Avenue.

Correction of Facial Asymmetry in an Adult

LEO JAMES GROLD, D.D.S., Los Angeles

The Problem

IN THE CORRECTION of asymmetrical facial anomalies in adults, it is primarily necessary to obtain proper and efficient occlusion with an improvement, if possible, in esthetics. In the case to be discussed here, extreme enlargement of the right mental protuberance was present (Figs. 1 and 2). The teeth occluded mesially. The median line extended to the right the width of the mandibular incisor (Figs. 3 and 4).

The Patient

History—A man, aged 23, presented himself for treatment on February 10, 1936, because of asymmetrical malocclusion. Because the patient was an actor, the deformity had for him economic and social connotations.

Examination—The patient was in normal health. The voice and tongue were normal; the tonsils were slightly enlarged, and the nasal septum was diverted. All maxillary teeth were present with alveolar retraction. The mandibular left first bicuspid was missing; it had been extracted at the age of 21 (Fig. 5). The mandibular right first molar had been extracted at the age of 9. There was a separation of 5 mm. between the two right bicuspids (Fig. 6).

Family History—The patient's parents, brothers, and sisters showed no orthodontic anomaly.

THE PATIENT AND THE PROBLEM:

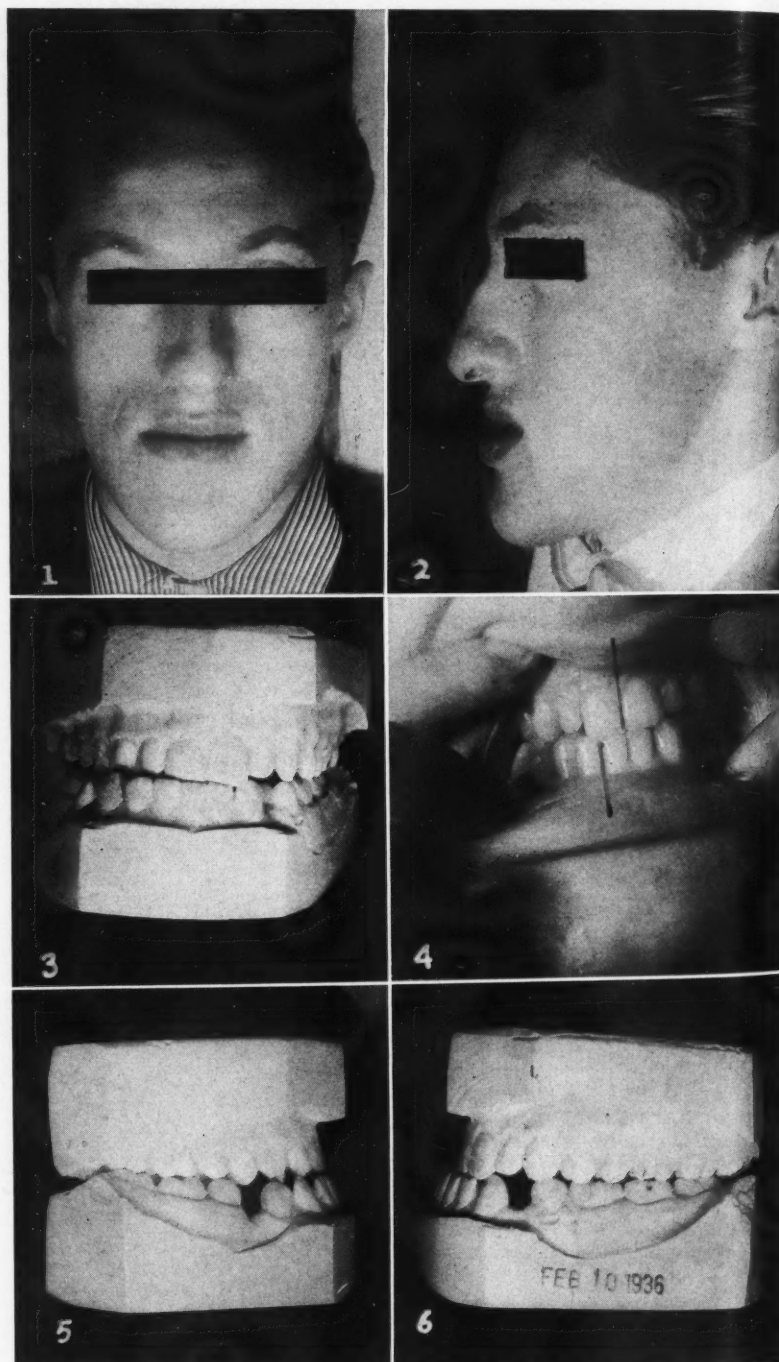
Fig. 1—Front view of patient before treatment. Note definite asymmetrical development of the face with right mental protuberance enlarged.

Fig. 2—Lateral view of patient with mandibular denture in protraction and an overdevelopment of facial muscles.

Fig. 3—Front view of model made when case was begun, February, 1936.

Fig. 4—Teeth in occlusion when patient presented himself for treatment.

Figs. 5 and 6—Lateral views of models when case was begun.



Etiology—Predisposing causes were the presence of enlarged faucial tonsils and of trophoneurotic disturbances. Trophoneurotic¹ disturbances often produce hyperdevelopment of the jaws and with it anomalies of dentition. Trophoneurotic disturbances are functional disturbances caused by the failure of nutrition from defective nerve influences. In this case the facial trophoneurosis was no doubt caused by an excessive nerve stimulation resulting in an atrophic muscular condition on one side and a hypertrophic muscular condition on the other side with its accompanying bone complement. In cases of acute anterior poliomyelitis there is generally present an atrophy of the muscular structure which in turn affects the bony structure, causing an atrophic condition in the bone. The reverse applies in a hypertrophic muscular condition which is caused by the trophoneurotic disturbances.

The exciting cause was the prolonged retention of the right second deciduous molar, which was extracted at the age of 12. The abnormal occlusion that the retention of this deciduous tooth developed would naturally be forward, causing definite facial asymmetry.

Diagnosis—A total maxillary alveolar retraction was present with a total mandibular alveolar mutilated protrusion.² There was bilateral mesio-occlusion with linguoversion³ of the right maxilla. A marked asymmetrical development of the face and jaws was manifested.

The Procedure (Figs. 7, 8, 9)

Maxillary Appliance—1. A labial arch, .026 stainless steel, was attached to the four upper incisors and cuspids.

2. The McCoy⁴ open tubes and buccal tubes were used on the first molars.

3. A stop was welded mesially to the buccal tube, and .001 stainless steel spring with an expansion of approximately 2 mm. was placed, and the arch snapped to place.

¹Herbst, Emil: Etiology of Malocclusion. Internat. J. Ortho. & Dent. Child. 21:233 (March) 1935.

²Simon, P. W.: On Gnathostatic Diagnosis in Orthodontics. Internat. J. Ortho. & Oral Surg. 10:755, 1924.

³Lischer, E. E.: Etiology of Dental Anomalies. Internat. J. Ortho. & Dent. Child. 21:9 (January) 1935.

⁴McCoy, J. D.: Applied Orthodontics. Fourth Edition. Philadelphia, Lea & Febiger, 1933. Page 220.

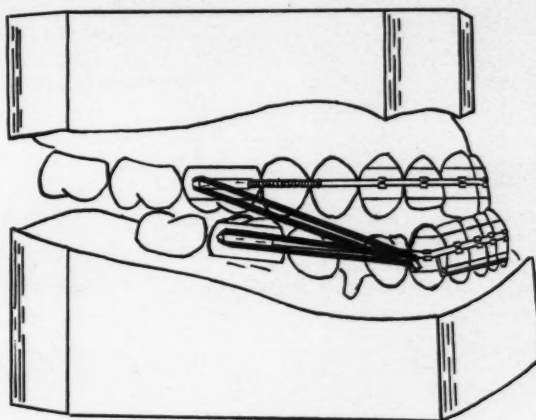


Fig. 7

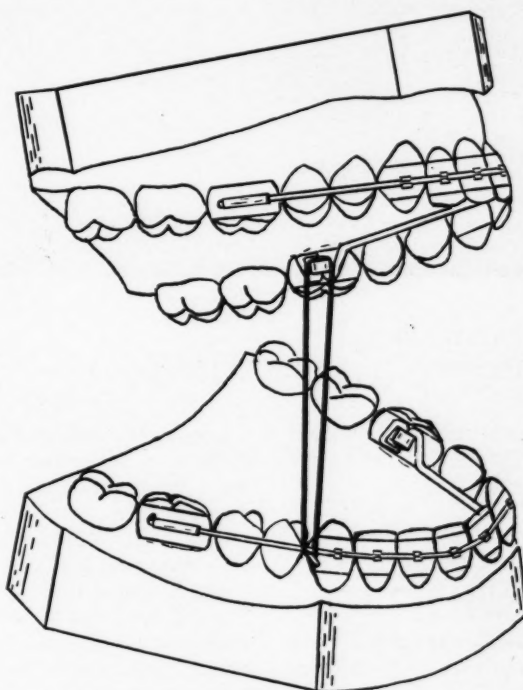


Fig. 8

THE PROCEDURE:

Figs. 7 and 8—Maxillary and mandibular appliances.

4. A lingual arch of .036 stainless steel was placed and permitted a slight widening in the bicuspid and molar area.

Mandibular Appliance—1. A labial arch of .026 stainless steel was placed, attached to incisors and cuspids by McCoy open tubes.

2. The arch was permitted to slide

freely in the buccal tubes attached to the second right molar and first left molar.

3. Mesial to the cuspids a .016 wire was welded to the arch on each side, bent gingivally to rest on the labio-lingual surface of the incisors to cause their bodily movement.

4. Hooks were placed in the arch

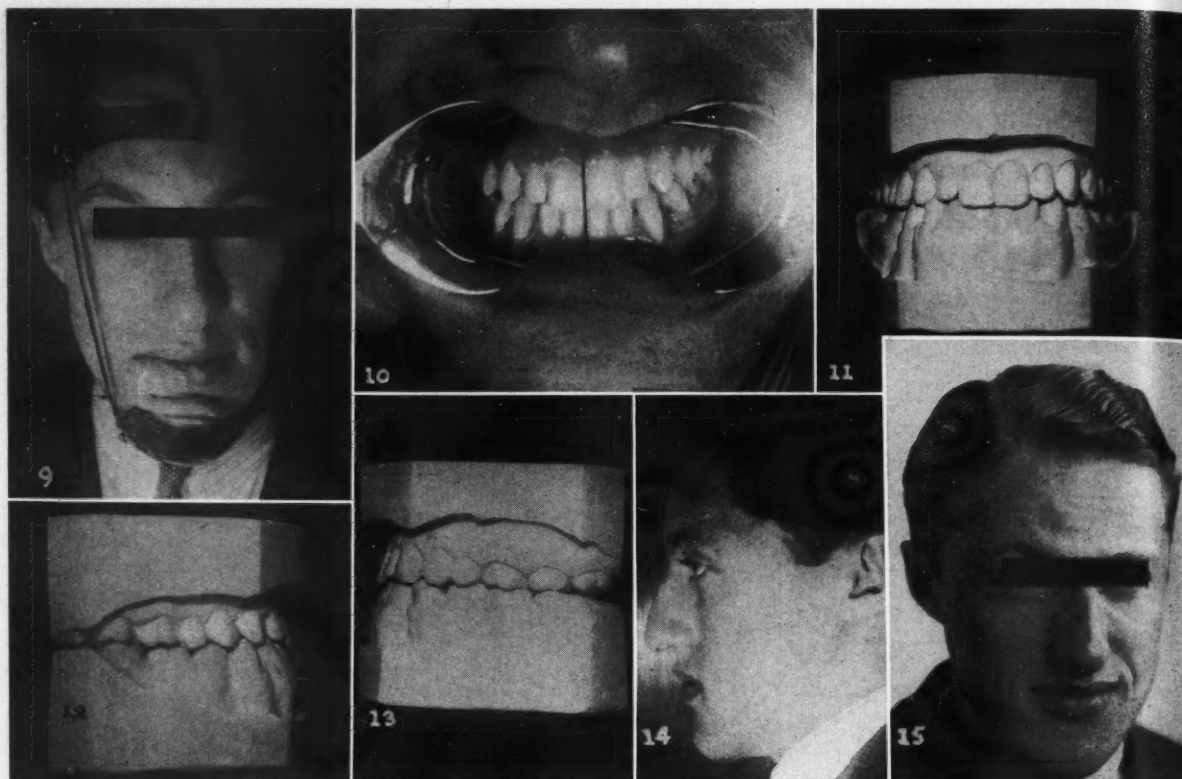


Fig. 9—Extra-oral appliance.

THE POSTOPERATIVE RESULT:

Fig. 10—Occlusion two years after treatment was begun.

Figs. 11, 12, and 13—Models two years after treatment was begun.

Fig. 14—Present lateral view.

Fig. 15—Patient as he looks at present.

just distal to the cuspids for attachment of intramandibular and intermaxillary rubbers (Fig. 7).

5. A lingual arch was placed in horizontal tubes, welded on the lingual surface of the molar bands to augment the control of the lower teeth in their distal movement.

6. The continuous use of the intra-mandibular elastics and intermaxillary elastics brought the mandibular teeth distally. An elastic was then placed from the hook distal to the right cuspid to the lingual of the upper left molar (Fig. 8). This diagonal elastic caused the mandible to rotate slightly. It no doubt produced pressure on the distal surface of the left mandibular fossa and articular tubercle, thereby stimulating the osteoclasts to absorb the matrix, and allowed the condyle to assume a distal position. This is shown clinically by the difficulty the patient now has to assume the original asymmetrical position.

Oppenheim⁵ has demonstrated the response to bone stimulation by pressure. Hemley⁶ states, "Bone is destroyed at the site of pressure and grows in the direction of pressure." This statement is certainly applicable to the mandibular fossa and condyle.

At no time was the patient inconvenienced by the use of the diagonal elastic, immediately accommodating the tongue to this additional torsional force. This treatment was augmented with an extra-oral appliance (Fig. 9).

Extra-Oral Appliance—1. An impression was made of the chin.

2. A stainless steel tray was adapted, swaged, and welded with hooks; a slight space was allowed for the right mental protuberance.

3. A felt hat was cut and hooks were welded and sewed at a point just dis-

tal to the orbit and distal to the ear (Fig. 9).

4. A powder puff was placed in the position of the chin tray at the point of enlargement of the right mental protuberance.

5. Rubber bands were placed over the hooks with double pressure applied to the affected side.

The Postoperative Result

Movement and functional occlusion were obtained, along with a pleasing esthetic result, through the simple expedience of the use of a diagonal elastic which appears to be an innovation in the treatment of an asymmetrical case of the type reported here.

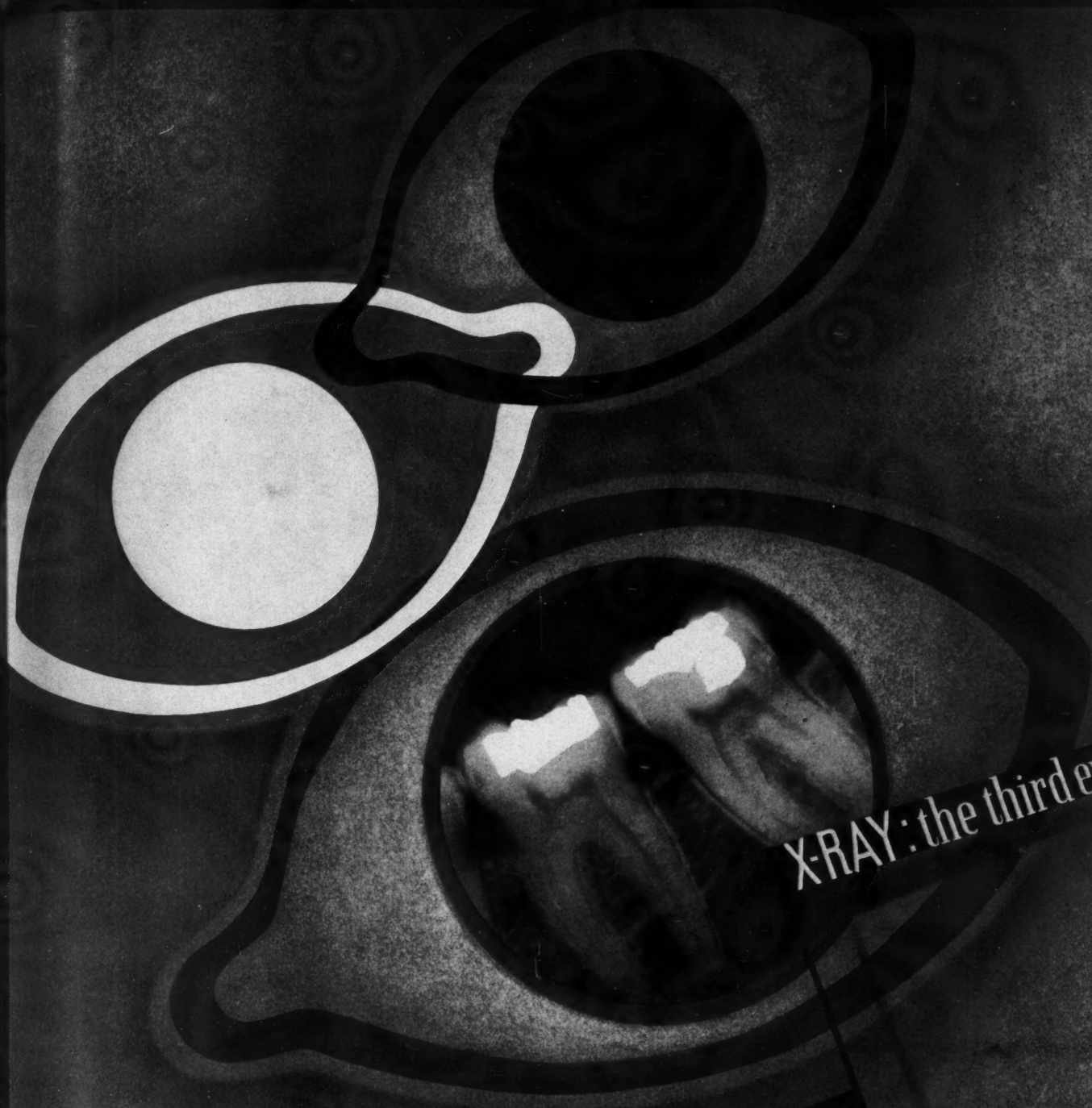
The prognosis is good. With continuous use of the extra-oral appliance for some time at night, it is my opinion that the protuberance will gradually disappear and occlusion will remain normal (Figs. 10 through 15).

Loew's State Building.

⁵Oppenheim: Tissue Changes, Particularly Those of Bone, Incident to Tooth Movement, *Am. Ortho.*, Number 2, Volume 3, Number 3, Volume 3.

⁶Hemley, Samuel: A Rationale of the Application of Mechanics in the Treatment of Malocclusion, *Internat. J. Ortho. & Oral Surg.* 22:782 (August) 1936.

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X-RAY: the third eye

20 REASONS for dental x-rays

WILL
STEIN-
FELD

Twenty Reasons For Dental X-Rays

ALBERT J. WHITFIELD, D.D.S., San Francisco



Fig. 1—BEGINNING DECAY. Beginning decay is not always due to lack of proper mouth hygiene. It is often a forerunner of serious metabolic or glandular disturbances. Tooth decay is a disease. It cannot be seen early with the eye alone.

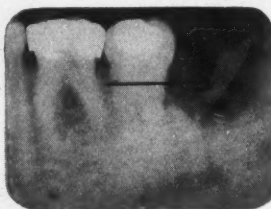


Fig. 8—SEQUESTRUM OR DEAD BONE. When part of a bone dies, it is thrown off (sequestered). This is one of Nature's methods of ridding the bone of the infected part. Common causes of bone sequestration are: direct injury, infection, and chemical poisoning.

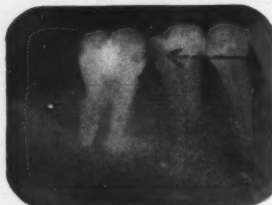


Fig. 2—DENTAL CAVITIES. Dental cavities are the end-result of beginning decay as described in Fig. 1. When unchecked or neglected, the dental "nerve" or pulp becomes involved and will "die." Infection results.

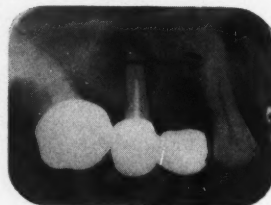


Fig. 9—CURVED ROOTS. Many teeth have curved or deformed roots and other deviations from the normal, which make their extraction difficult.

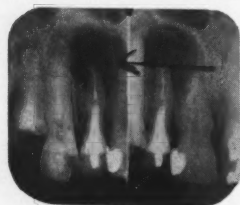


Fig. 3—ABSCESSED TOOTH. An abscess, either acute or chronic is a circumscribed area containing pus. Abscessed teeth are recognized factors in many ailments, such as high blood pressure, stomach and duodenal ulcers, inflammation of the eyes, nerves, joints (arthritis), sinuses, skin eruptions, kidney and heart disease.

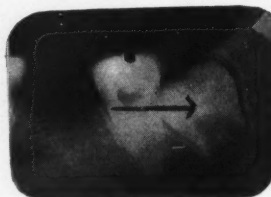


Fig. 10—UNERUPTED AND PARTLY DEVELOPED LOWER THIRD MOLAR (WISDOM TOOTH). Un-erupted and partly developed "wisdom teeth" are often responsible for mal-formed arches and crooked teeth.

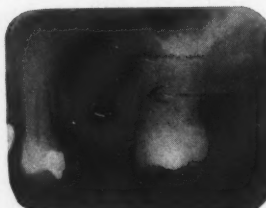


Fig. 4—ROOT CYST IN THE UPPER JAW. This cyst in the upper jaw resulted from the retained root-tip shown in the illustration which was discovered only by "x-ray" examination. Undetected dental cysts or abscesses in the upper jaw are often responsible for sinus disease.

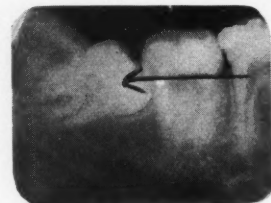


Fig. 11—IMPACTED LOWER "WISDOM TEETH." An impacted lower "wisdom tooth" is often associated with swollen glands in the neck. Such impactions are also identified with gum infections, such as Vincent's infection (trench mouth) owing to organisms lodged in pockets created in the gum tissue surrounding the crown of the impacted tooth.



Fig. 5—AN ABSCESSED BROKEN ROOT-TIP UNDER A BRIDGE. A condition such as this could have been prevented, if an "x-ray" examination had been made before the bridge was placed. The root-tip would have been noticed and removed.

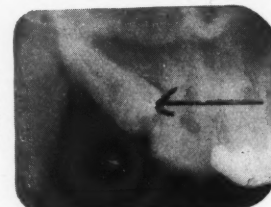


Fig. 12—IMPACTED UPPER "WISDOM TOOTH." Many nervous disorders may be attributable to impacted teeth. Their extraction is advisable.

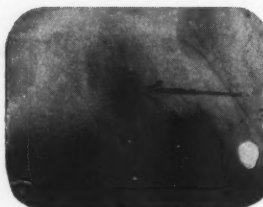


Fig. 6—RESIDUAL INFECTION IN THE UPPER JAW. Residual infection is a localized chronic condition occurring in the jaw bones after teeth are extracted. Only the "x-ray" can discover these areas early.



Fig. 13—INFECTED ROOT TIP PROJECTING INTO MAXILLARY SINUS. Infected root tips bordering on or projecting into the sinus are often seen in "x-rays," and their occurrence is often responsible for sinus disease. Their immediate removal is important to health, and great care must be exercised at the time of their extraction.

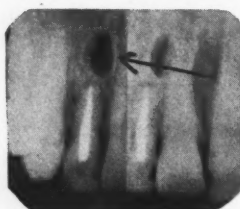


Fig. 7—RESIDUAL INFECTION FOLLOWING ROOT CANAL TREATMENT AND ROOT AMPUTATION. The dark area is the result of residual infection following the devitalization (removal of the pulp) of the lateral incisor tooth. Root canal treatment and root amputation in this case proved inadequate.



Fig. 14—A DRIFTING TOOTH AND ABSCESS DUE TO PYORRHEA. When a tooth has been extracted, adjacent teeth in good position move as a result of chewing pressure. This is known as drifting. When a tooth is lost, a bridge should be constructed immediately to prevent further tooth movement, and possible pyorrhea.



Fig. 15—BEGINNING PYORRHEA. Beginning pyorrhea may be due to lack of proper mouth hygiene, lack of stimulation of the gums, and also soft foods. "X-ray" examination will disclose this condition in its various stages.

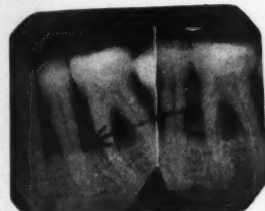


Fig. 16—ADVANCED PYORRHEA. Pyorrhea, a disease detrimental to health, attacks the gums and also destroys the bone that supports the roots of the teeth. An early sign of this disease is bleeding gums. When unchecked, the affected tooth or teeth must be extracted. Dental "x-rays" will reveal the condition early when its treatment is most advantageous.

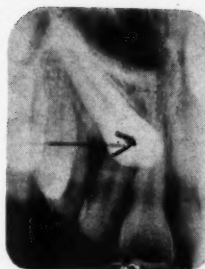


Fig. 17—IMPACTED CUSPID (EYE TOOTH). Impacted cuspids may be causative factors of nervous disorders, headache, and iritis (inflammation of the eye). Discovery of impacted cuspids by means of the "x-ray" and early removal has been reported to aid in the cure of these conditions.

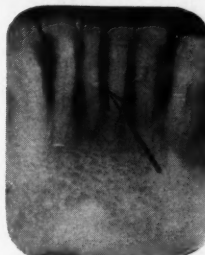


Fig. 18—CALCULUS (TARTAR). Calculus is a deposit frequently found on the necks and roots of teeth. Deep "tartar" is revealed by the "x-ray." It should always be removed as it acts as a gum irritant, producing soreness, bleeding and spongy gums, and is often associated with pyorrhea.

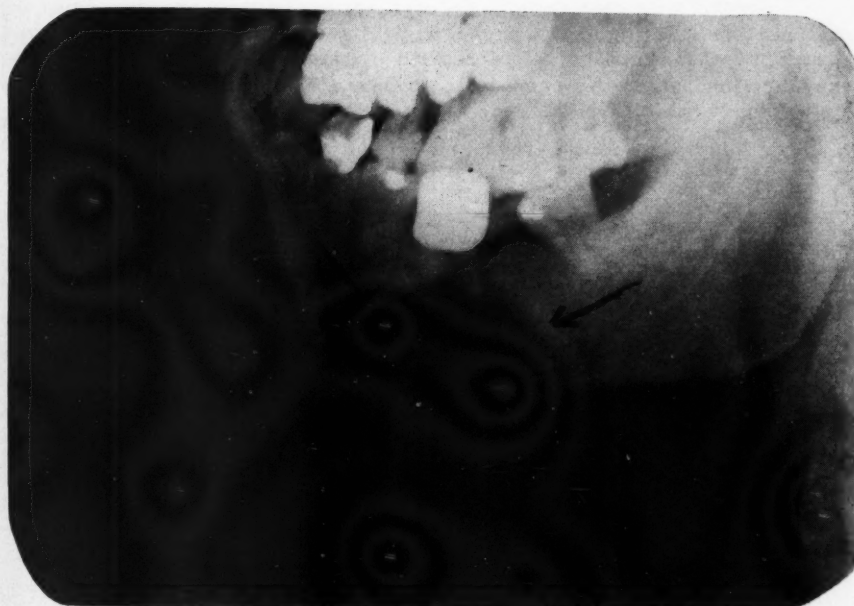


Fig. 19—A LARGE CYST OF THE LOWER JAW. A cyst is a circumscribed cavity with a well defined, organized lining membrane or sac, containing a fluid or semifluid substance, which may be either sterile or infected. Patients are usually unaware of the presence of a cyst until it is revealed by the "x-ray." As a rule they are painless unless infected. Their early discovery and removal is important, as fractured and disfigured jaws are often the result of undetected cysts.

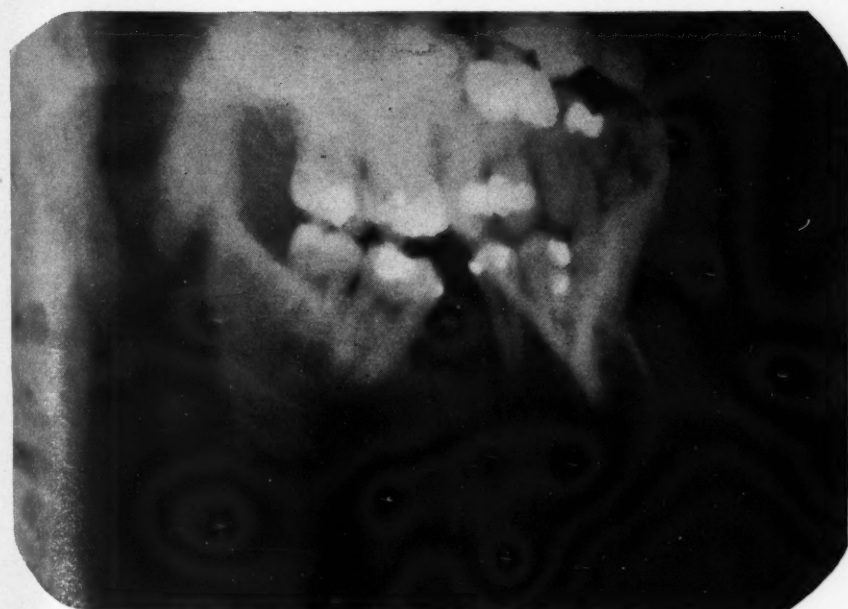


Fig. 20—FRACTURED (BROKEN) JAW BONE. The "x-ray" is a valuable adjunct in making a diagnosis of a fracture, as it aids in determining the type, location, and severity of the break. Fig. 20 shows a multiple fracture of the right side of the lower jaw, resulting from an accident.

Reprints of this feature, **TWENTY REASONS FOR DENTAL X-RAYS**, are available for distribution to patients at the regular reprint rates.

Anodontia: Report of a Case

LOUIS W. SCHULTZ, JR., B.S., D.D.S., M.D., Chicago

A WHITE GIRL, aged 3 years, was presented because of the absence of teeth. The child appeared well developed and well nourished (Figs. 1 and 2).

History—At birth the patient weighed 4 pounds, 8 ounces. Delivery had been normal and spontaneous after an eight-month pregnancy. There were no convulsions at birth. The infant was placed in an incubator and kept there for forty days. Feedings had been normal throughout infancy and included orange juice and cod liver oil.

The child had been gaining and growing progressively but when at 9 months of age she did not have any teeth, her mother consulted a physi-

cian who told her not to worry, that teeth would erupt later. At 2½ years of age, the mother again consulted the physician who referred the patient to me.

The patient had been immunized against diphtheria and vaccinated against small pox. She had had whooping cough at 8 months of age of six months' duration, but had had no other diseases or sicknesses. No surgery had ever been performed nor had the child incurred any accidents.

Habits of eating, elimination, and sleeping were good.

Family History—The mother had had two miscarriages before the birth of the patient. No one else in the family had anodontia. There was no

history of tuberculosis, diabetes, or cancer in the family to the informant's knowledge.

Physical Examination—Skin: The skin was warm and moist and there were no abnormalities; tissue turgor was good and subcutaneous fat was abundant.

Head: There were no abnormalities on the scalp. Hair was abundant and of normal distribution. The ears appeared normal; the canals were clear; the drums within normal limits; there were no topi. There was no nasal discharge and the septum was intact. The pupils of the eyes were round and equal and reacted to light and accommodation. There was no ptosis, nystagmus, or strabismus.

Fig. 1



Fig. 2



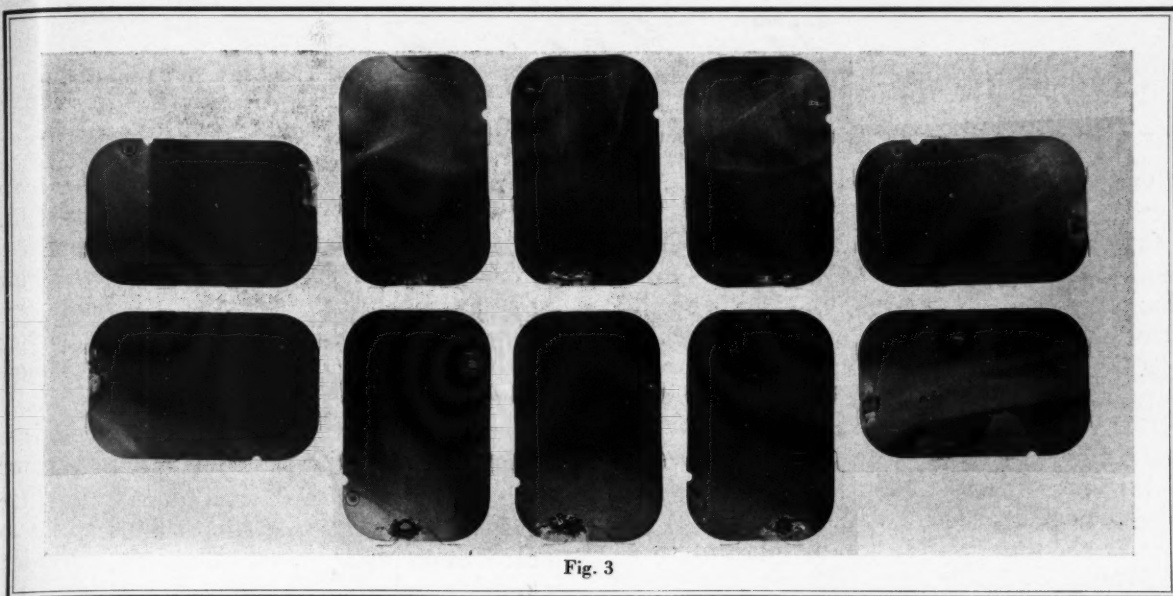


Fig. 3

Neck: There was no rigidity or lymphadenopathy.

Chest: Expansion was good and equal; resonance and breathing sounds were good throughout. There were no audible rales.

Heart: All observations were within normal limits.

Abdomen: The abdomen was protruding and obese. There were no scars or palpable masses. There was no rigidity or tenderness.

Extremities: Motion was good in all directions; there were no abnormalities. Development was good.

Back: There were no abnormalities.

Reflexes: Obtainable reflexes were within normal limits.

Examination of the Mouth—The lips, mucous membranes, and gums were of good color. Teeth were absent. The alveolar ridge was present. The tongue was moist and red. The tonsils were small and slightly reddened. The pharynx was normal.

Laboratory Reports—Chemical analysis of the blood and urinalysis showed no significant results.

Roentgenographic Examination—Roentgenograms of the jaws showed complete absence of tooth buds (Fig. 3).

Recommendation—The construction of full upper and lower dentures for the patient was advised.

Incidence—There have been sev-

eral reports¹ in the medical and dental literature of cases of anodontia.

25 East Washington Street.

¹West, J. Van Gilsevan: Anodontia with Hair Anomalies: Case, Nederl. Tijdschr. v. Genesek. 1:1185 (March) 1929.

Thadani, K. J.: A Toothless Type of Man: The Bhuddas of India: A Case of Sex-Linked Inheritance, J. Heredity, 12:87, 1921.

Hopson, M. F.: Complete Absence of Deciduous and Permanent Teeth, Proc. Roy. Soc. Med. (Sec. Odont., part III), 13:23, 1921.

Radasch, H. E. and Zifferblatt, A. H.: Embryologic Factors Determining Anodontia, D. Cosmos, 72:658 (July) 1929.

Apfelthaler, M.: Ein Fall von angeborener Zahnlosigkeit (Anodontia Congenitalis), Vrtljschr. f. Zahnk. Berlin, 41:91, 1925.

Etheridge, F. L.: A Case of Partially Suppressed Dentition and Growth of Hair, British D. J. 29:66, 1913.

Kohlfirber, F.: Ueber angeborenen Zahnmangel im menschlichen Gebiss, Leipzig, 1925.

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The Editor's Page

EVERY MAY the dental literature stresses articles on the child as the dental patient. Some of the articles are sentimental; others, technical and scientific and entirely divorced from the human personality who is the child. The child needs and is entitled to early and adequate dental care, but there is no need to become sentimental about it. The child is likewise entitled to the same quality of technical skill as the adult, but in applying this skill there are sometimes difficult human factors involved in the management of the child patient. The parent is an important factor in this problem.

Walter C. McBride of Detroit, one of the outstanding periodontists in the country, in an address before the Wisconsin State Dental Society, emphasized that in about 10 per cent of cases a behavior problem is presented on the part of the child or a management problem on the part of the mother. His classification of parent types and dentist types is worth repeating: McBride divides parents into four types, examples of which we can recall in practice:

First there is the distracting type, the mother who stands in the operating room and by her generous promises to the child tries to direct his mind from the procedure. McBride points out emphatically that at the moment of the dental operation there is no power of suggestion or persuasion that can distract a person's attention.

Second is the cooperative type, the mother who stands at the chair-side and repeats every suggestion or comment offered by the dentist. When the dentist says, "Please open your mouth, Willie," mother repeats the chant after him.

Third is the courage-builder, the one who prepares her child for the ordeal as if she were preparing a son for battle.

Fourth is the sympathy-extender, the mother-knows-it-hurts type.

What is done to build up the morale of the child before he comes into the dental office is something that the dentist has little power to

control but he can put matters under his own control in the dental office. He can exclude from the operating room effusive and loquacious parents. The time consumed in entertaining parents is time wasted from the operative procedure. If the parent knows that she is paying for the entertainment hour, she is much more likely to remain in the reception room.

McBride's classification of dentist types is as understanding as his classification of parents:

First, there is the dentist who is afraid of the child; he is afraid to speak to him; afraid to meet him on his level. This dentist's indecision is quickly reflected on the child's attitude toward treatment: the child knows instinctively that he can out-bluff the dentist.

Second is the doting type, the dentist who talks down to the child, the baby-talker, if you please, the Hello-girly; the Isn't-Mother-proud-of-her-big-strong-boy type.

Third is the patronizing dentist who attempts to be Dale Carnegie-ish with too much flattery to the child.

The fourth type of dentist is the most objectionable: he is the teaser.

McBride makes these positive suggestions: Develop the sense of comradeship with the child which means to identify him by his name and approach him through his interests. Of all the techniques to use in child management, shame, says McBride, is the poorest equipment. Comparisons with other children, giving the child a sense of inferiority, is never the method to produce a satisfactory and friendly relationship. The abrupt dentist who plunges forward to operations without preparing the way by explanations is not likely to have tractable child patients. A few minutes spent with each child in explanation and preparation is time well spent.

Doctor McBride places the economic aspect of dentistry for children on a sensible basis. Restorations are not sold as so much each. The cost of dentistry for the child is determined by the difficulty of operation and the response of the child.

**FLASH
BACK**
TO
The Dental Digest
October 1936
VOL. 42, NO. 10

Practical Application of the Immediate Temporary Bridge

RALPH L. IRELAND,
B.S., D.D.S.,
Lincoln, Nebraska

THE IMMEDIATE REPLACEMENT of extracted anterior teeth is always a troublesome problem, especially in emergency cases. The use of the immediate temporary bridge for these cases has proved of inestimable value. As previously described¹ these bridges are easily and quickly made (See Flashback illustrations). They are placed in position immediately after the teeth have been extracted and

¹Ireland, R. L.: Immediate Temporary Bridges for Anterior Teeth, *DENTAL DIGEST*, 42:340-343 (October) 1936.

1—After a compound impression is taken of the tooth, baseplate wax is adapted around upper part of band. A small amount of wax is trimmed away from the inside of the wax ring down to the copper band.

2—Number 10 tin foil burnished around crown of model to form matrix.

3—Finished three-quarter crown on model.

4—Metal flowed around pins of vulcanite teeth.

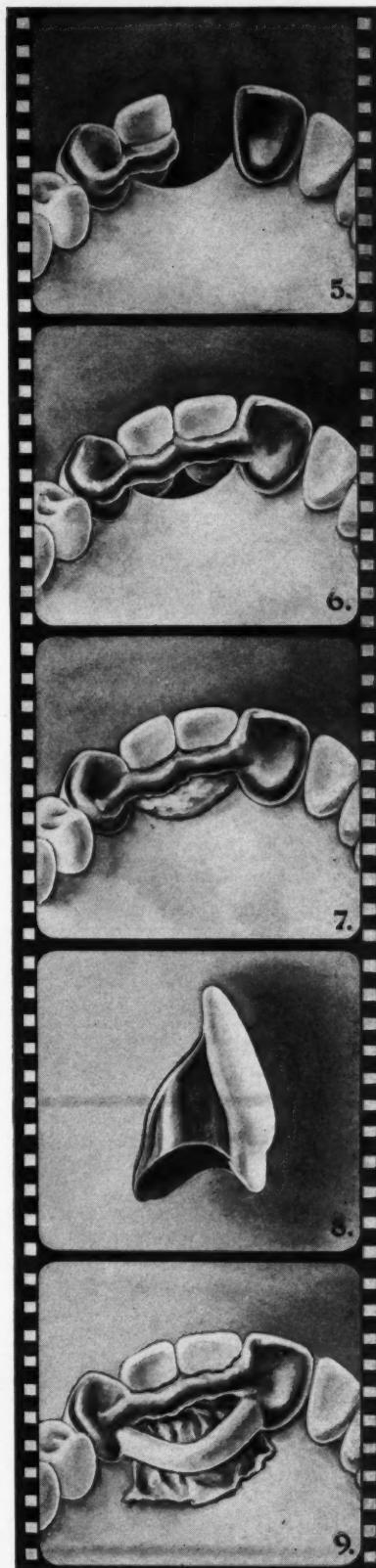
5—Attachment of first tooth in a four-tooth bridge.

6—Attachment of second tooth in four-tooth bridge, showing metal connecting the two teeth.

7—Moldine packed over the sockets and built up to within a few millimeters of the pins.

8—Finished case, showing concavity of saddle as the result of packing moldine over sockets.

9—Tin foil in place with moldine superimposed. This forms a reservoir for pouring the low-fusing metal in making the saddle.



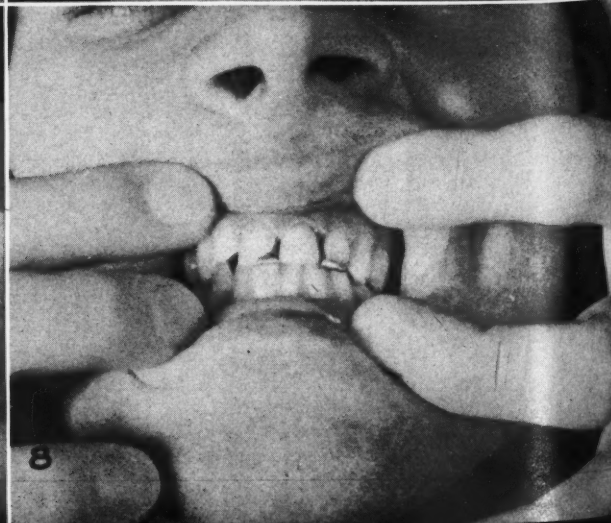
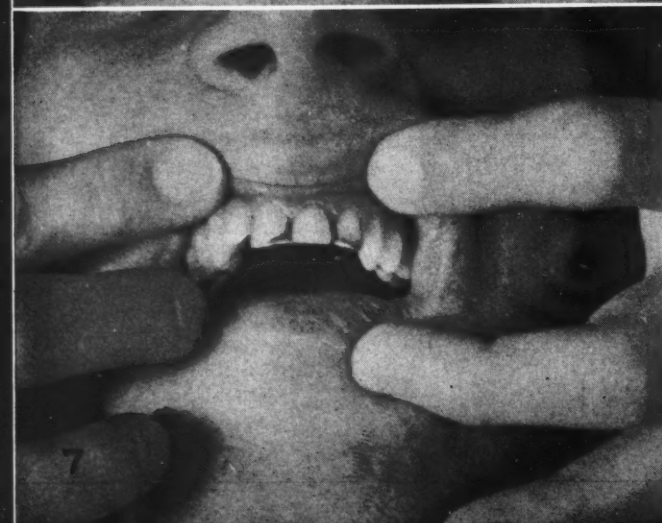
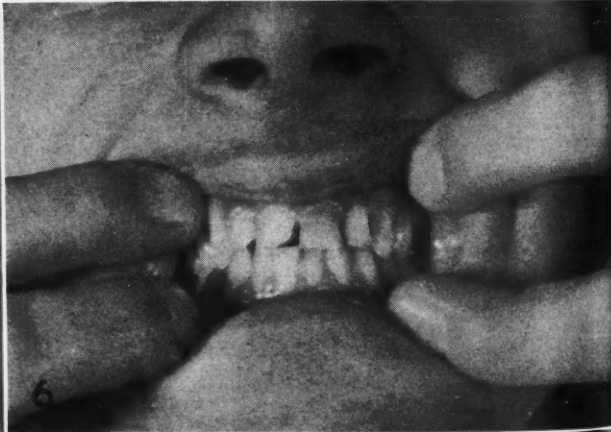
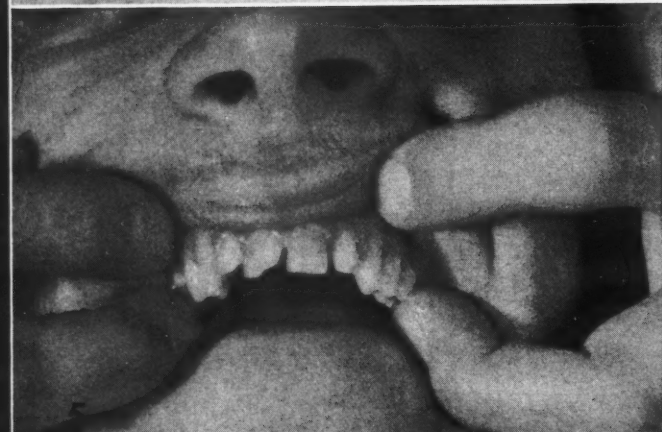
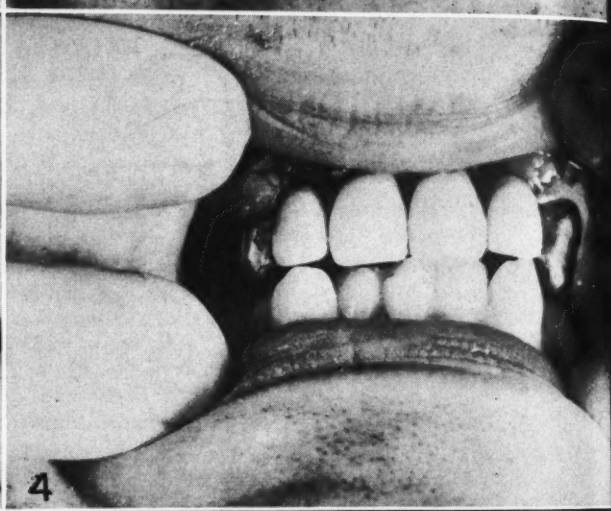
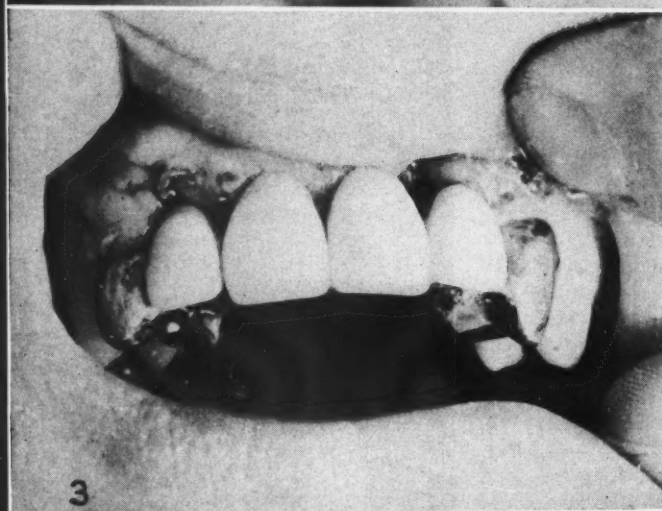
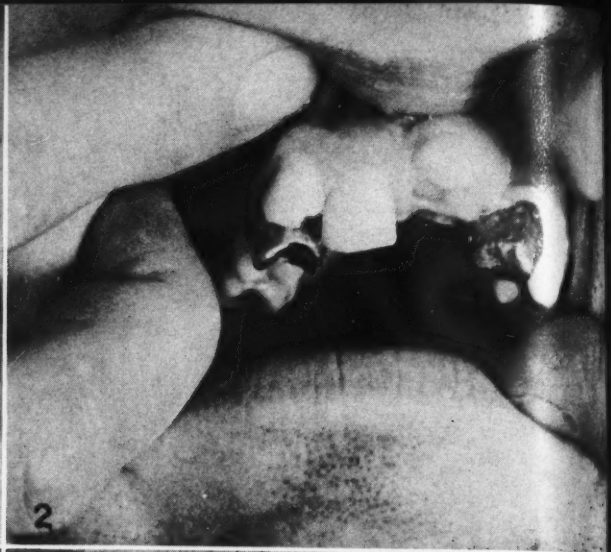


Fig. 1—Two days after right maxillary incisor was extracted. First bicuspid have been prepared for full-cast crowns.

Fig. 2—Low-fusing metal crowns have been made and are in position on first bicuspid, prior to taking the bite and impressions.

Fig. 3—Temporary bridge in position immediately after teeth have been extracted.

Fig. 4—Immediate temporary bridge in occlusion. As the patient's mouth was small, the crowns were not visible while he was talking or smiling.

Fig. 5—Before extraction.

Fig. 6—Before extraction with teeth in occlusion.

Fig. 7—Immediate temporary bridge in position after maxillary central incisor had been extracted.

Fig. 8—Another view of temporary bridge with teeth in occlusion.

worn until the permanent bridge is ready to be inserted.

The accompanying pictures (Figs. 1

through 8) illustrate the practical application of these bridges.

Report of Cases

CASE 1—A university student, aged 20, participated in an intramural boxing contest, and when first seen presented a loose left maxillary central incisor. Roentgenographic examination revealed the root to be completely resorbed owing to pressure exerted by the maxillary right cuspid which was in mesio-torsi-infra-occlusion. The lateral incisors were congenitally missing. The loose central incisor was held in position by only the gum tissue, and was extracted immediately. The remaining three teeth in the anterior region were in extreme malposition. It was decided to extract them and construct a six-tooth bridge from first bicuspid to

first bicuspid (Figs. 1 through 4).

The immediate bridge was worn by the patient for two and one-half months. He reported that he experienced no difficulty in eating and his speech was not affected, as is often the case with the horseshoe type of partial.

CASE 2—A man, aged 24, had a pulpless left maxillary central incisor which it was necessary to extract (Figs. 5 and 6). The patient's occupation kept him constantly before the public, and this made an immediate substitute imperative.

A class 4 silicate restoration had previously been placed in the right central incisor. This preparation was utilized as one abutment for the temporary bridge (Figs. 7 and 8).

*Andrews Hall,
University of Nebraska.*

Examination for Appointment in the Dental Corps of the Navy

A competitive examination to select not more than twenty for appointment in the Dental Corps of the Navy will be held on July 5, 1938, at the Naval Medical School, Washington, D. C., Naval Training Station, Great Lakes, Ill., and Naval Training Station, San Diego, Calif.

A candidate for appointment in the Dental Corps must be a citizen of the United States, and must be between 21 and 32 years of age at the time of appointment, a graduate of a standard dental college, of good moral character, and of unquestionable professional repute.

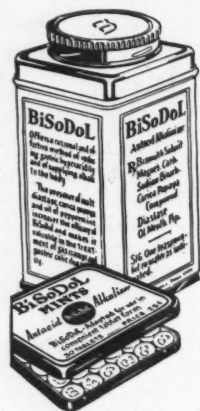
Credentials relative to character, citizenship, date of birth, and education must be submitted and approved before an applicant can be authorized to appear for examination.

Senior students in dental colleges may submit applications to appear for the examination held next after their dates of graduation. They should submit with their applications and credentials a letter from the dean of their dental school stating that they are members of the senior class, and immediately after receiving their diplomas a letter from the dean or registrar of the dental school that they have received the Degree of Doctor of Dental Surgery or Doctor of Dental Medicine as the case may be.

A circular which contains full information relative to the Dental Corps and describes the method of making application for appointment may be obtained from the Bureau of Medicine and Surgery, Navy Department, Washington, D. C.



AFTER EXTRACTION



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THE DENTAL DIGEST

1005 Liberty Ave.

Pittsburgh, Pa.

TO THE Editor

"SPARKPLUG" DENTAL CHAIR FOR CHILDREN

THE STANDARD DENTAL chair is too large for most patients under 10 years of age. There is a small chair manufactured which is more adaptable for children; but such a chair requires the investment in an additional unit, cuspidor, instrument cabinet, and operating light; thus involving the expenditure of many hundreds of dollars beyond the cost of the regular equipment; moreover, additional rent must be paid for the additional space thus required. Obviously it would be desirable to have something which



could be added to the regular chair, something which would permit the child's body to be raised sufficiently high so that satisfactory results could be obtained without the necessity for another chair.

I have accomplished this with an old cast-off saddle from which I removed the posterior flange. The head and body of the horse were cut out from 2 inch wood with a band saw and fastened to the saddle. This was covered with imitation leather by an upholsterer. The eyes were made with my son's two white marbles on which I painted the pupils. The mane was made from monkey fur taken from one of my wife's discarded dresses. The saddle is laid on top the seat of the dental chair, and stabilized with cords provided at the rear of the saddle to permit tying it to the dental chair. The device measures 26 inches in length and weighs 10 pounds.

A child often shrinks from the dental chair and it is a problem to get



V

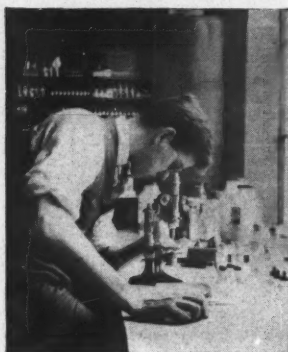
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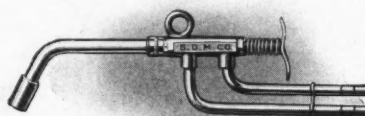
AT THIS time dentists should be reminded that no matter what cement is used, during the warmer months cement mixing requires a different technic than is used during the winter. The cement should be spatulated more rapidly during periods of extremely high temperature. We will gladly give any interested dentist special information on hot weather mixing technic. As all Ames users know, it is easy to get a good mix with Ames under any conditions, summer or winter.

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BUFFALO DENTAL MFG. CO., BUFFALO, N. Y.

him into it. The device described here captures his interest and it is easier to coax him into the chair. Moreover the child patient will frequently push the dentist away with his hands as soon as the latter approaches him with an instrument. It would be desirable to tie the patient's hands first in such cases, if this could be done without unduly exciting him. The "Sparkplug" chair permits this to be done pleasantly and tactfully, without force:

"Now you understand, Johnny, that this is a fast horse, and you are apt to be thrown off, especially when going around turns; therefore, I'm going to fix these reins on your wrist so that you can hang on much better."

This is done with slip buckles as shown in the photograph. These loops can be fastened to the wrists quickly, but are difficult for the patient to remove. When the dentist is ready to start operating, he can first unobtrusively pull on a strap end which goes through a third slip buckle. This takes up the slack in both reins, because the strap plays freely through the horse's mouth, permitting it to be pulled through from either side. The child's hands are thus pulled forward out of the way and held there securely, usually before he is aware of what is happening. I do not tie the child's hands as a rule for restorative dentistry except in cases in which I anticipate that I will be unable to reason with the child.

Another advantage results from the presence of the pommel which serves to prevent "scooting" forward in the chair, something most children are likely to do.

The "Sparkplug" chair is ideal for the administration of nitrous oxide. When Johnny wakes up, he finds that Sparkplug has taken him for a ride and that he has lost one or more teeth along the route.

—G. A. STEVENSON, JR., D.D.S., 166 East 154th Street, Harvey, Illinois.

Visual Education in Dentistry: A new (and complete) edition of the charts "The Education of the Dental Patient" now available.

See pages 229-230-231.

Suggestions for the use of

The Ryan Examination and Treatment Record

1. The Ryan Examination and Treatment Record may be had in pads of fifty charts each. These pads fit conveniently in a standard 9½ by 11½ inch loose-leaf notebook which may be purchased at a five-and-ten cent or variety store.

2. Alphabetical dividers may be made by using a ten cent package of plain white paper of the same size as the charts with holes punched at the same distances, and a fifteen cent box of alphabetical index tabs. The holes are reinforced.

3. It is a good plan to keep a blank sheet of paper between the charts to prevent possible smearing of crayon or pencil markings; but this is not essential.

4. A fresh pad of charts may be kept ready for use in back of the notebook of active records.

5. The various types of restorations and their location in a particular mouth are shown with the use of polychrome pencils—gray, for amalgam; deep yellow, for gold. White pencil does not show up very well; consequently, porcelain may be indicated with soft lead pencil outlines or cross-hatching.

6. Spaces provided beside the quadrants with numbers corresponding to the teeth permit special notations concerning each tooth. As treatment progresses the blue markings indicating needed dentistry are erased, and the nature, location, and date of placement of each new restoration are recorded. Additional clinical notations are made if necessary in the space provided for that purpose below the chart itself.

7. It is essential to be consistent in any system of symbols or markings developed. To insure consistency, it is well to have a key page in the front of the notebook.

8. The exact record of conditions found in the average patient's mouth at the original examination can be completed in fifteen or twenty minutes, and the time it takes to keep a chart up to date is negligible.

9. When a chart is completed the necessary data (name, address, telephone, reference, estimate, and terms) are typewritten in the spaces provided at the top of the record. The date of the original examination is also recorded in order that the treatment dates (as shown in the quadrants at the sides of the chart) will be recognized as subsequent to the date of the original examination.

10. Provision is made on the back of the chart for bookkeeping records. This is merely for the convenience of dentists who wish to keep all records together, but may be ignored by dentists who have a satisfactory book-keeping system which they need not and do not wish to discard. The Ryan Examination and Treatment Record may be employed as an additional or supplementary record to any established method of record-keeping dentists may have.

11. Although the Ryan Examination and Treatment Record was designed for the dentist's own convenience in his practice, the charts have been found to have a definite informative value in explaining conditions to patients. The charts are also particularly helpful in reporting dental conditions of patients to cooperating physicians.

TYPES OF PENCILS

Yellow	Mongol No. 867
Gray	Mongol No. 819
Red	Mongol No. 866
Blue	Mongol No. 865
Yellow	Castell No. 40
Gray	Castell No. 57

Mongol pencils are made by Eberhard Faber; Castell by A. W. Faber.

SUGGESTED SYMBOLS

Each dentist may develop his own system of symbols but the following specific markings have been found simple and adequate:

Soft Lead Pencil—(a) Porcelain fillings are indicated by a pencil outline.

(b) Porcelain jacket crowns and bridges are shown by cross-hatching with lead pencil across the corresponding tooth or teeth on the chart.

(c) Missing teeth are blocked out with a soft lead pencil.

(d) Abrasions are represented with soft lead pencil.

Blue Pencil—(a) Cavities are indicated with blue pencil.

(b) Advisable restorations are demonstrated with blue pencil.

Red Pencil—(a) A red line is used to indicate the presence of a root canal filling.

(b) A red outline shows the presence and position of an impacted tooth.

(c) Red pencil is used to represent pulp involvement.

(d) A red "X" is made across a tooth to indicate that its extraction has been advised.

(e) Pyorrhea pockets are represented in red along the crest of the alveolar ridge (and a notation is made at the bottom of the chart if extensive gingivitis is present).

THE DENTAL DIGEST, 1005 LIBERTY AVE., PITTSBURGH, PA.

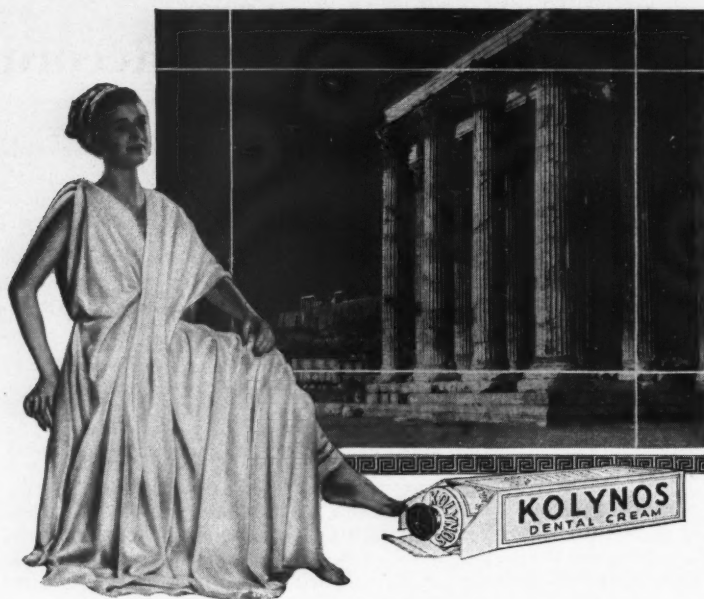
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102

Please Note

SPECIAL ANNOUNCEMENT

On Pages

229 - 230 - 231

NOTES ON THE

Cuff

March 23—We need an Emily Post in dentistry to tell dentists how to sign their names; when to use degrees; when to use "Doctor"; and particularly to tabu the joint use of "Doctor" and "D.D.S." or "D.M.D." "Doctor Henry Dill" at the end of a letter is irksome enough but "Doctor Henry Dill, D.D.S." is too much. (Henry Dill is the name of no actual person living or dead. The name is purely fictitious. The existence of such a person is not known to the editors and would be a coincidence: This, to copy the common cinema practice to avoid libel.)

March 25—Speaking of "Doctor": A solicitation note in the morning mail from the Encyclopaedia Britannica is addressed to "Doctor Hygiene Oral" and another from a social agency to "Mrs. Hygiene Oral." Somebody is selling somebody a phoney mailing list.

March 29—Speaking before the Norwegian-American Hospital Medical Staff on the subject of identification through dental records. In the discussion that followed, one physician described his experience in identifying his son who was killed in an airplane accident. Porcelain jacket crown restorations were the only certain means of identification.

There seems to be more interest among physicians in the matter of adequate and accurate dental records than there is among dentists. That is probably because physicians are more in the habit of keeping accurate case histories and records than we have been.

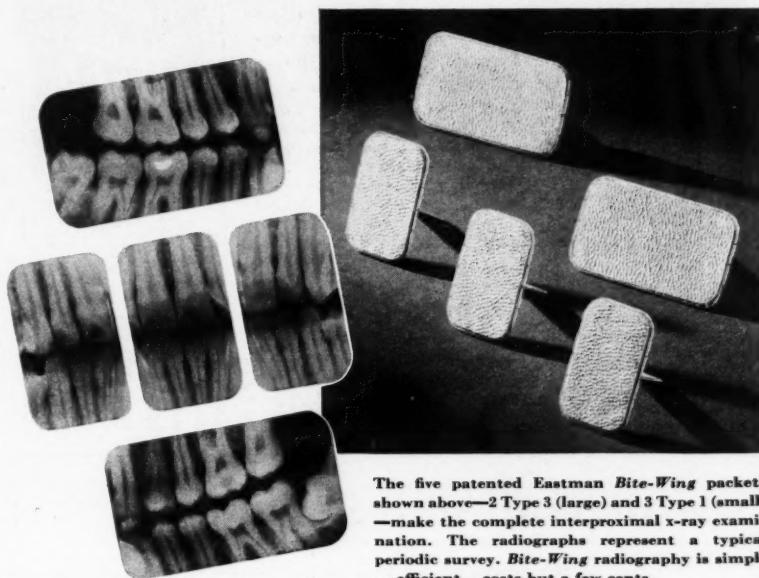
April 1—All Fools' Day and one of the press services reports that an old gent, aged 91, is cutting his third set of teeth. This gag crops up two or three times a year when news is scarce. What people do not know is that these alleged third sets of teeth are probably the eruption of submerged teeth that have been present in the jaws throughout life. If anyone ever comes across authentic third dentition he should report it in the scientific literature.

April 4—In the April issue of *The*

Journal of the American Dental Association and The Dental Cosmos appears a long awaited article by a dentist concerning DANGERS IN DENTAL RECONSTRUCTION INVOLVING INCREASE OF THE VERTICAL DIMENSION OF THE LOWER THIRD OF THE HUMAN FACE. Russell Wilford Tench of New York warns that there are biologic aspects involved; that the loss of vertical dimension is Nature's attempt to relieve abnormal muscle strain; that no one has proved that hearing can be impaired by a closed bite or restored by opening the bite; that there is no formula by which to measure the degree of resistance of alveolar bone to a given degree of strain or by which to "determine the degree of strain developed in function by the musculature of the masticating apparatus for each degree of bite opening." Doctor Tench says, "These bite openers and occlusion advancers are gifted with a peculiar form of reasoning. They, on the one hand, condemn Nature for being too inefficient to effect adjustments of function that they assert may be disturbed by a closed bite, but they forget that when the bite is opened, even by a super-dentist thoroughly grounded and trained in the procedures necessary, Nature is called on abruptly to make several adjustments without which their efforts are doomed to failure. And their efforts do result in failure in far too many instances; for Nature does make adjustments to secure biologic balance, and often shortens the face to the original short dimension . . ."

April 7—The papers are excited over the speech by James H. Means, M.D. before the American College of Physicians. Doctor Means calls for revolt against the American Medical Association in these words: "The behavior of the American Medical Association is political. It is partisan behavior. It champions a cause. At the present time the cause is something close to stand-patism. The electorate of the American Medical Association is apathetic and inarticulate because it has no issues." What lies beneath these headlines in this flamboyant talk? Probably medical politics. A comparable situation might be found if an officer of the American College of Dentists uttered a similar tirade against the American Dental Association. There are internal politics in the professions as everyone knows. By all means, within the group, free and

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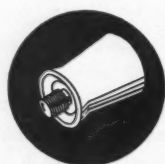
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realistic debate should be encouraged. Flight to the newspapers to discuss our internal problems is not commendable. Whenever dentists have something to say in criticism of their own organization, it would be well to say it without the press. No good can ever come from scrubbing our linen in public.

April 9 through 17—Lecture-Travel Log:

Saturday: Opening the season in Brown County Indiana State Park. Cold blasts blowing through the cracks in a cottage wall send us to bed at eight o'clock.

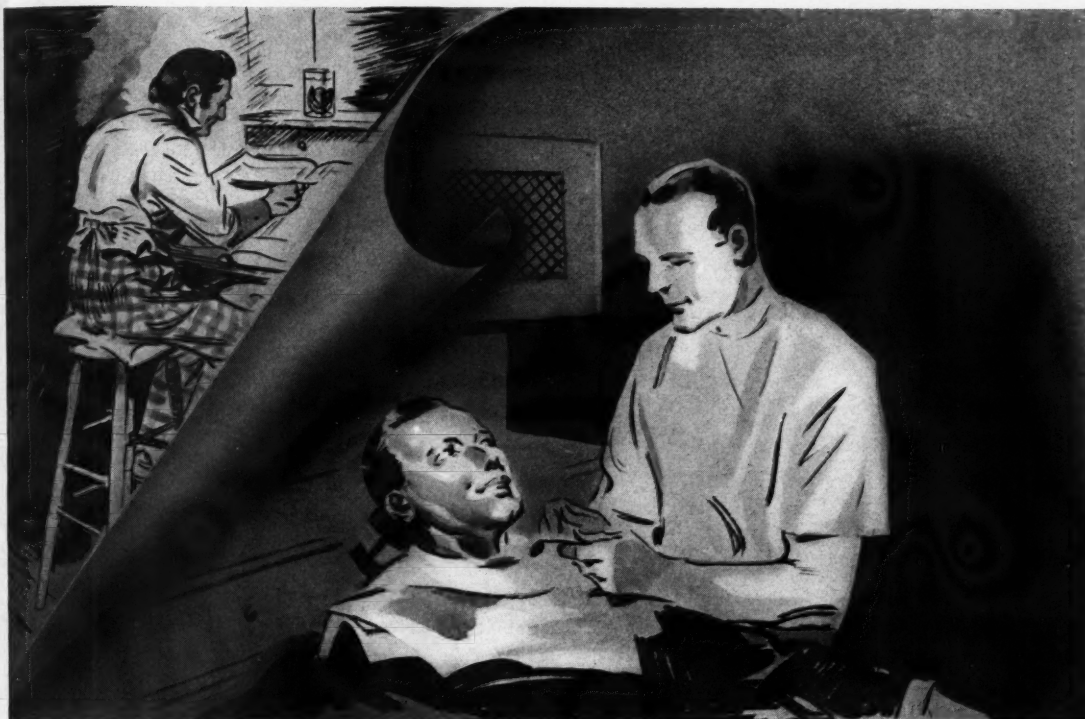
Sunday: From the rude puncheons of a Brown County cabin to the splendor of the Netherland Plaza Hotel in Cincinnati—from the horseback riding trails in the hills of Indiana to the plush carpets of one of America's finest hotels.

Monday: Breakfast with the Carlos Schotts and the Fred Blacks at the Schotts' magnificent Forest Hills home. Luncheon: Speech-making before the Kiwanis Club of Cincinnati where the reporters for the *Cincinnati Post* and *Times-Star* got the story straight. Afternoon: With Eddie Ball to see the layout for his new office in the Doctors Building, Cincinnati. Ball's material on periodontal disease, including wet anatomic specimens and photographs, is some of the best in the country. More speech-making at the dinner and evening meeting of the Cincinnati Dental Society.

Tuesday: Across the Ohio River at 5:30 A.M., driving more than 500 miles to Birmingham, Alabama. On the way, underneath gay umbrellas in southern Tennessee, peltries of the red and silver fox are offered for sale: a touch of the days of hunting and trapping. Through the mountains, white with the blossoms of dogwood, over the dusty detours, we arrive in Birmingham at dark.

Wednesday: Morning: Talk at the Tutwiler Hotel before the Alabama State Dental Association. Afternoon: Swimming and horseback riding. Dinner with the Willard Farmers and a contest at shuffle board with Ralph McClung.

Thursday: To Nashville and a quick visit with Oren Oliver, Roy Elam, and Jim Vaughan. It is vacation week from school so two young daughters have accompanied us and now demand an overnight stop at a tourist camp which we make at Bowling



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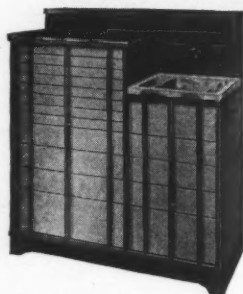
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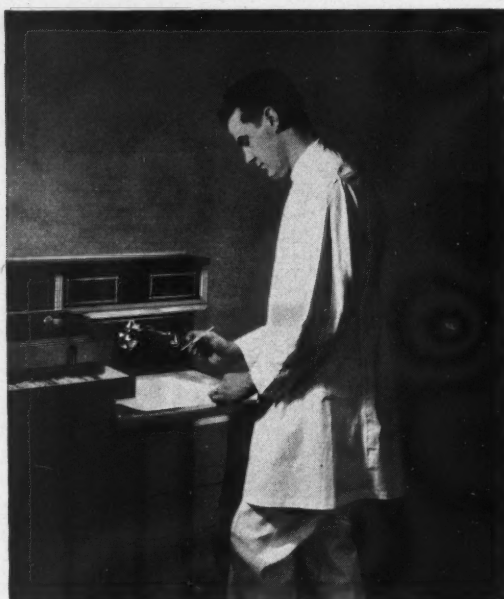
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Green, Kentucky. The tourist camp seems to catch something of the old wagon train days. During the informality of the evening, campers talk of the miles covered, the road conditions, and the trip ahead. One remembers the diaries of the 'Forty-Niners and the stories of the trips across the great plains. There is a little of that recaptured in the tourist camp where the people talk with one another about the places they came from and the places they are going to and of all the rigors and adventures along the way. Someone could do a bit of Americana on this subject.

Friday: Up and away to Mammoth Cave and Lincoln's birthplace at Hodgenville and on to Louisville.

Saturday: Another day in the saddle at Turkey Run State Park. Earl Graham, Secretary of the American Dental Association Relief Commission, and his family were also enjoying the Park.

April 19—George Selleck of San Francisco, speaking before the Chicago Dental Society, tells the story of his colleague who never had any trouble with his denture cases. Asked to what he attributed his successful technique, his colleague replied, "I don't have the trouble; my patients have all the trouble."—E.J.R.

DENTAL MEETING

Dates

American Dental Society of Europe, Stockholm, Sweden, August 1-3.

The State Board of Registration and Examination in Dentistry of New Jersey will hold its annual examinations, commencing June 27, and continuing for five days thereafter. Complete details can be secured from Walter A. Wilson, D.D.S., 148 West State Street, Trenton.

American Association of Orthodontists, thirty-sixth annual meeting, Roosevelt Hotel, Los Angeles, California, July 11-14.